Witness Name: Duncan Selbie

Statement No. 1

Exhibit DS1-7

Dated: 24.05.2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DUNCAN SELBIE

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1 I, Duncan Selbie, will say as follows:

2 I make this statement in response to the request (M1/SELBIE/01) from the UK COVID-19 Inquiry ("the Inquiry"), dated 14 March 2023, requesting a witness statement from me on a number of matters relating to Module 1.

3 I was employed as the Chief Executive of Public Health England ("PHE") from July 2012 to August 2020 which is the time period that the Inquiry have an interest in. I am no longer employed within the UK, and currently reside and work in the Middle East. I remain committed to assist the Chair of the Inquiry, and although I am not in a position to return to the UK, I will make myself available to give evidence remotely at any time as requested by the Inquiry.

4 At the outset of this statement, I want to acknowledge the unprecedented loss of life and harm caused by the pandemic and the impact that this had on families, the most vulnerable in society and the economy that we are still living with today. I fully support and recognise the importance of this Inquiry to highlight the lessons

that should be learned in order to be better prepared in the future and I will assist the Inquiry in achieving their Terms of Reference in any way that I can.

5 Before joining PHE, I was the Chief Executive of Brighton and Sussex University Hospitals, the regional teaching hospital for the southeast of England (July 2007-July 2012). Between November 2003 and July 2007, I worked for the Department of Health, initially as the Director General of Programmes and Performance for the NHS and then as Director General of NHS Commissioning. From January 2002-October 2003 I was the Chief Executive of the South East London Strategic Health Authority and prior to that Chief Executive of South West London and St George's Mental Health NHS Trust (January 1997-December 2001). Between 1980-1996 I held various NHS posts in Scotland and London.

6 These roles involved creating and leading multi-disciplinary teams and leading at national level and at the frontline of healthcare which provided me with the background and experience that prepared me for the role of Chief Executive of PHE. On my appointment as PHE's Chief Executive, Ministers recognised that I was not a public health expert or a scientist but that I had the strategic and operational experience required to deliver the mandate to build a new organisation and team capable of protecting and improving the nation's health. In this, as in my previous Chief Executive roles, I was supported by a team of exceptional professional and expert talent.

7 My role as the Chief Executive was to lead the creation and running of the new organisation and ensure that the organisation had the professional expertise and resource it needed to deliver what it had been tasked to do. It was not my role to give health protection or scientific advice to officials or ministers, this being reserved to the clinicians, public health specialists, EPRR professionals and scientists trained for this purpose. This was well understood by the Secretary of State, Chief Medical Officer and Permanent Secretary of the day who authorised my appointment.

8 As Chief Executive, I was supported by an Advisory Board comprising an independent non-executive Chair and non-executives appointed by the Secretary of State for Health and a smaller number of associate non-executives appointed by the Board to bring expertise to bear in particular areas. This included infectious disease through Professor David Heymann, an internationally

respected expert in infectious disease, who served as Chair from 2013 to 2017 (formerly Chair of the Health Protection Agency), and Professor George Griffin, a former Chair of the Government's Advisory Committee on Dangerous Pathogens and previously a non-executive of the HPA's Board, and Professor Sian Griffiths, an expert on global health. PHE's governance arrangements were reviewed and assured by an independent Audit and Risk Committee, whose work was informed by an annual programme of reviews by the Government Internal Audit Agency and external scrutiny by the National Audit Office. I established and chaired the PHE National Executive, which subsequently became the Management Committee, to support me in leading the organisation, the majority of members being medical, scientific and public health professionals. A small number of executive committees were established to ensure oversight and delivery in particular areas, with Professor Sir Paul Cosford, Director for Health Protection and Medical Director, chairing one on EPPR Oversight with an EPRR Delivery Group reporting to this. The governance arrangements were set out in detail in PHE's statutory annual report and accounts.

9 I hold an MSc in Health and Hospital Management and Dip HSCM from the Institute of Health and Social Care Management. I am the current President of the International Association of National Public Health Institutes (IANPHI), elected in December 2020. [1]

10 I am an Honorary Professor at Robert Gordon University Aberdeen, an Honorary Professor at the University of Chester and have an Honorary Doctorate in Public Health from Chester University and an Honorary Doctorate of Science from the Robert Gordon University. I am an Honorary Fellow in the Faculty of Public Health of the Royal College of Physicians, and a Companion of the Institute of Health and Social Care Management.

11 I have lived and worked overseas since October 2020 and have not had access to documents held by PHE/UKHSA since I ceased to be the Chief Executive of PHE in August 2020.

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[1] IANPHI is an association of the directors of 115 National Public Health Institutes (NPHIs) and its members include the directors of China CDC, the U.S. CDC, the public health institutes of Cuba, Thailand, Brazil, Mexico, South Africa, Ethiopia, Nigeria, India, France, Germany, Scotland, Wales and England. IANPHI's mission is to improve health outcomes by building capacity within and between its member NPHIs.

12 In order to prepare this statement, I have requested and reviewed a small number of documents and spoken with a small number of previous PHE colleagues to assist me in refreshing my memory. Where I have considered documents to provide my response, I have provided the INQ reference number where this is available. I will also need to rely on the Inquiry bringing to my attention any documents that they would wish me to consider.

13 I note that the Inquiry have already received a detailed corporate witness statement from Dame Jenny Harries the current Chief Executive of UKHSA (14 April 2023) which provides an overview of PHE's history and its functions. The Inquiry have not repeated this request of me and instead I have been asked to provide my general views on a number of topics, which I have answered within the scope of my own experience as I have set out above.

14 I confirm that I have read the witness statement of Dame Jenny Harries and I am in broad agreement with the information provided. I have not been able to read the many supporting exhibits other than exhibits I refer to in this statement. Like Dame Jenny Harries, I acknowledge that the corporate statement has been drafted with the input of a significant number of experts within UKHSA, including colleagues who previously worked for PHE. I also rely upon their knowledge and clinical and scientific expertise in terms of their input into this statement.

15 Before addressing some of the more specific questions that the Inquiry has asked, I wish to set out my views on a number of issues. The first is that PHE was created to fulfil a number of functions. These are set out in UKHSA's corporate statement and the annual remit letters (Exhibit DS1 INQ000090332 - INQ000090338). Unlike UKHSA, PHE was not created by government with the principal purpose of being 'stand up ready' for the scale of pandemic preparedness and response that became apparent was required and were not funded on this basis. My view based on my own experience, is that PHE was well prepared for the emergency health protection work that it was commissioned by DHSC to perform (expanded upon in more detail within the body of this statement and in the UKHSA corporate statement) but was not fully prepared to deal with the scale and magnitude of the pandemic of unknown origin that the world faced in January 2020.

16 The pandemic preparations that were in place during my time as PHE Chief Executive related to an influenza pandemic, as this was the most prominent risk on the UK National Risk Register since 2008 and remained the case up to January 2020. PHE scientists supported the Chief Medical Officer, DHSC and Cabinet Office in making their assessment. PHE was not prepared, or asked to be prepared, for the level and scale of resource required to respond to the COVID-19 pandemic. In my view and within the limit of my own knowledge and expertise that I have explained above, the focus of risk on an influenza pandemic was, but only with the benefit of hindsight, misplaced.

17 UKHSA was created during the pandemic, and funded by the government specifically to ensure the UK was able and ready to prepare and respond to future pandemics at scale and over time. This was not the mandate for PHE when it was created. On this basis I do consider that the UK is in a better situation, with respect to pandemic planning and response, than was the case in January 2020. However, my view must be taken in the context of having left PHE in August 2020 and having not worked with UKHSA since it was created.

18 The role of public health and government are fully intertwined. Public health policy is created by government and cannot succeed without its funding and political support. The then Government's vision in 2012 was to create an organisation that for the first time would bring the three branches of public health, health protection, health improvement and healthcare public health together into one integrated national organisation which was PHE. This was in recognition that health disparities (Marmot Review 2010-updated 2020 / Global Burden of Disease) affect the poorest and most deprived people with the poorest health, the hardest. The intention for local government having more control over local public health strategies was to try and tackle these stark health disparities and recognise that the NHS had limited impact in recent decades on prevention and only partially contributed to overall improvements in life expectancy.

19 It should be noted that by the time of my appointment as PHE's Chief Executive, the policy decisions about PHE's establishment and role had been subject to parliamentary scrutiny and had been decided. The White Paper 'Healthy Lives, Healthy People' published in November 2010 set out the vision for a new public health system with strong local and national leadership (Exhibit DS2 -

INQ000090323). My responsibility as Chief Executive was to create and lead the PHE team to deliver the vision that the Government had already determined.

20 The functions of the HPA were successfully and smoothly transferred on a "lift and shift" basis into PHE in 2013 and under the professional leadership of Professor Sir Paul Cosford, who had been the HPA Acting Chief Executive Officer and Director for Health Protection, and Professor Christine McCartney who was the Director for the specialised and regional microbiology laboratories. The safe transition of these critical functions was addressed by the Health Select Committee in their report on this period, "the Committee recognises that throughout the transition PHE maintained continuity of the vital work undertaken by the Health Protection Agency" [Exhibit DS3 INQ000090340].

21 The late Sir Paul Cosford led on health protection and the EPRR function in PHE until May 2019 and Professor McCartney led on public health microbiology until the creation of the National Infection Service in 2015. The new National Infection Service brought together public health microbiology and epidemiology to create integrated teams to focus on specific types of infections. This was led by Professor Derrick Crook, seconded to PHE from the University of Oxford, and subsequently Professor Sharon Peacock from the University of Cambridge from 2019 onwards. PHE embedded the local health protection teams that came from HPA as a core part of its new regional centres and to support local government and other system players, including the NHS, when it came to local health protection. Every local authority had a qualified and experienced director of public health (as a chief officer, tier one) transferred from the NHS. Transition to local government was as carefully delivered as the transfer of responsibilities from the HPA and other sending organisations to PHE.

22 The transfer of responsibility for *health improvement* from the NHS to local authorities resulted from Government policy, set out in the White Paper and then in the annual remit letters, that reflected that the main determinants of good health outcomes are largely determined by prosperity, decent housing and social cohesion. NHS services are of course important but do not have such a significant impact as economic, societal and environmental factors. Local

Authorities were expected to be better placed to improve these wider determinants, supported by a national professional agency (PHE) tasked with health improvement on behalf of the Secretary of State as well as a health protection function.

23 When comparing the HPA to PHE, the UKHSA corporate statement sets out the HPA's functions prior to the creation of PHE in 2013. In terms of comparisons when looking at the move of responsibility to local authorities, I am aware that during the 2009 influenza pandemic there was a direct line of sight between central government and the frontline NHS, that included health protection services, which potentially assisted in being able to manage that outbreak. This included the Department of Health, Primary Care Trusts (PCTs), NHS Hospital Trusts and HPA.

24 This can be contrasted with the arrangements after the Health and Social Care Act 2012 and the formation of PHE, and where the public health expertise moved from PCTs into local government who became responsible for local health protection and improvement. Although PHE also had regional Health Protection and Screening and Immunisation Teams, the critical difference was that there was no longer the direct line of sight by central government regarding frontline health protection through the NHS, as there had been before. This had given government an ability to flex and redirect resources and have the situational awareness of what was happening locally.

25 During the 8 years of PHE's operation my experience was that local government worked effectively with PHE's health protection teams, who set out protocols and expectations to them, in managing approximately 90% of local infectious disease outbreaks the remainder being managed directly by PHE either due to their scale or complexity. I enclose the independent MORI annual stakeholder survey of PHE where local government and other stakeholders highly rated the support they received from PHE (Exhibit DS4 INQ000182704).

26 During my time as Chief Executive of PHE I did spend a great deal of my time 'out in the field' and met every upper tier Local Authority in England. As a result of this experience my view is that local government were better able to establish where local risks were through their resilience plans for civil threats (floods, fires etc), and could direct resources accordingly. This was a positive step. However,

devolving this responsibility locally might also have resulted in directing resources away from areas that national government may have given higher significance. And there was no longer the same power of direction that there had been when the NHS was responsible for health protection services. I anticipate that later modules of the Inquiry will consider the ability of national government to direct the response to COVID-19 in more depth.

27 There is also a wider point on funding. When public health services were the responsibility of the NHS they were at risk of being deprioritised during repeated funding pressures. The Chief Medical Officer report of 2005 spoke to this, recognising that public health budgets inevitably got raided to fund acute Trust deficits. It is my experience that governments prioritise the NHS and treatment over prevention services or strategies.

28 With PHE as part of the civil service, there was no funding protection for the organisation which is illustrated in the UKHSA corporate statement. Similarly, the public health grant was reduced in real terms from 2015 year-on-year. The public health grant was the subject of a report from the House of Commons Public Accounts Committee (Public Health England's grant to Local Authorities 19 January 2015 Exhibit DS5 INQ000182705). This sets out some of the challenges faced at this time regarding local authority public health funding including the disparity of funding between local authorities. The report also notes in the summary that PHE '*has made a good start in its efforts to protect and improve public health. Good public health is vital to tackling health inequalities and reducing burdens on the NHS. We were impressed by the passion shown by PHE's Chief Executive, and his determination to challenge Government to consider public health in wider policymaking.*'

29 PHE and transition from HPA was subject to review including the Cabinet Office Tailored Review carried out in 2017 (Exhibit DS6 INQ000090341). The whole report requires consideration but part of the conclusion was '*that PHE performs necessary functions and has made good progress with integrating the staff, cultures, working practices and physical assets of the variety of organisations from which it was created, building an organisation that provides expert advice on all aspects on health protection and improvement.*'

30 The UK Government's approach to risk assessment of infectious diseases during the lifetime of PHE is set out in the UKHSA corporate witness statement. It can be further illustrated by the PHE remit letters between 2014-2020, which were introduced in response to one of the recommendations made by the Health Select Committee's review of the transition and first six months of operation. Although these annual remits from DHSC Ministers focused most prominently on health improvement this was in recognition that the country needed to close health gaps, it was not to deprioritise health protection activity. Health protection was always the first priority of PHE and the Ministerial remit letters reflected this reality.

31 PHE supported the Secretary of State for Health and DHSC in their statutory responsibility to keep the country safe from infectious diseases and environmental hazards by managing thousands of health protection incidents each year expertly and effectively along with contributing to major national incidents in most years, including novel infections like Ebola and the Zika virus together with other catastrophic events including the Salisbury poisonings. In this, PHE followed and built upon the successful track record of the HPA and never lost sight of health protection as its primary duty over the eight years of its operation.

32 The details of PHE's involvement in pandemic planning is set out in the corporate statement. In summary, in 2011 DHSC published the UK's Influenza Pandemic Preparedness Strategy and in 2014 PHE published the Pandemic Influenza Strategic Framework and Response Plan.

33 An update to DHSC's National Pandemic Flu strategy was planned following Exercise Cygnus, to incorporate learning from that exercise. An update to the PHE Response plan was also planned to align with the new DHSC national strategy. The update to the national strategy did not progress due to national Government prioritisation around planning for EU Exit. As a result, the update to the PHE Response plan was also put on hold (as it was PHE's operational plan to deliver our parts of the national strategy). In terms of the effect of the pause on this review, as this was an influenza pandemic plan, any difference this would have made to the position in January 2020 is now unknown.

34 Although the 2014 Influenza plan was not reviewed in 2019 as planned, between 2014 and 2019 progress continued to be made regarding pandemic planning generally with the creation of the National Infection Service (NIS) which I have mentioned above. The progress and developments made within NIS are set out in the UKHSA corporate statement.

35 The corporate statement also sets out the progress made by PHE in establishing a High Consequence Infectious Diseases programme to support its response to a significant outbreak within this category. The learning from this programme was transferred to business-as-usual functions.

36 PHE had a formal system for responding to emergencies including pandemics. The National Incident Response Plan (NIERP) describes the operational details for responding to an acute incident including the way in which professionals within the organisation were mobilised and directed. The Emergency Response Team owned and operated the framework.

37 UKHSA's corporate statement gives a detailed account of the learning from simulation exercises. As set out in that statement, when PHE conducted a simulation exercise the parameters of the exercise and the consideration or action resulting from any recommendations made, rested with the commissioning body. The UKHSA corporate statement also sets out how PHE learnt from major public health incidents, including the MERS Outbreak in 2012, Ebola in 2013-2106 and the Zika virus 2015-2016.

38 In my view, despite the challenges that PHE faced with budget cuts over the years, PHE remained prepared for, and able to respond well to the requirements of normal public health operations within the arrangements for a system wide response led by DHSC and supported by the NHS and local government. This included responses to significant and serious events as outlined in paragraph 31 above. PHE managed cash releasing efficiencies and income generation to ensure that this was the case.

39 However, the UK and most other countries in the world, did not have a ring-fenced budget for 'pandemic preparedness'. PHE ran its emergency planning and preparedness as part of an allocated *peacetime* budget. If governments funded preparedness as an investment rather than a cost, this could save billions

when the next pandemic strikes. When looking at lessons to be learned, this may be an issue to consider. It is also important to consider how the cycle of 'panic and forget' is avoided for the future. There is a risk that where funding may be available for public health now, in 3 or 4 years' time when memories recede, the demands for funding elsewhere may result in funding being reduced or withdrawn rather than investing to reduce future risk.

40 PHE had a positive and long-standing relationship with the EU and the European Centre for Disease Prevention. There was a mutually beneficial relationship with the EU, in sharing data and professional expertise with respect to infectious disease and the consequence of the UK leaving the EU did have an impact on how this worked. The impact on PHE's funding as a result of leaving the EU is addressed in the UKHSA corporate statement as is the pause on the DHSC review of the 2011 influenza pandemic strategy as I have outlined above.

41 PHE had adequate provisions in place to effect a surge in public health outbreak diagnostic testing capacity and clinical testing when dealing with emergencies in normally forecasted public health operations, for example a measles outbreak. This would be delivered primarily through its network of regional microbiology laboratories and the national reference service at Colindale and working with the NHS who led on the majority of clinical diagnostic testing. Testing for any rare pathogens was primarily provided from Porton Down. PHE also had adequate capacity for clinical countermeasures, surveillance, and research in order to manage local and national emergency outbreaks and demonstrated this capability over the 8 years of its operation.

42 There was a well-established system for public health microbiology where PHE dealt with complex and new unusual cases that required specific expertise from the PHE laboratories, and where large scale microbiological diagnostic testing would be managed by the NHS. Again, this worked well during normal operations and PHE's capacity for testing was well understood by the CMO and DHSC officials at the time.

43 PHE were responsible for delivery of the DHSC strategy regarding pandemic stockpiles including procurement, maintenance and storage. The pandemic stockpile was procured on the basis of an agreed risk assessment of an influenza pandemic, based on scientific risk assessment explained above.

44 PHE developed an advanced surveillance system for infectious diseases, and I had no concerns with respect to PHE's capabilities nor was I aware of any gaps in reporting infections or fatalities or casualties during normal operations. However, these systems of surveillance that had worked well in the previous 8 years were not adequate for the massive scale and breadth of the surveillance required during the pandemic we were faced with. During this time much more detailed data was required to manage the risk, including use of social media, transport challenges and where people were going and moving to and shopping habits. I anticipate that these matters will be explored further in Module 2.

45 The UKHSA corporate statement speaks to the arrangements relating to ports of entry into the country and local Health Protection Teams role in providing advice and support to their local ports. PHE recognised that there was no written protocol of how organisations responsible for border control should work together. PHE approached DHSC with a proposal to carry out this work. DHSC agreed PHE's proposal in November 2019 and this was being started but stopped because of the pandemic.

46 I have already set out in this statement that in my view, PHE carried its emergency health protection work up to the point of January 2020 in the way that it was asked to do by Ministers. It is also my view that although PHE was not mandated or funded for at scale pandemic readiness and response, PHE did deliver on the tasks and responsibilities which were mandated by DHSC and the CMO throughout the first phases of the Covid-19 pandemic plan before UKHSA was created. I appreciate the detail of this is for module 2 but in my view it is also important to say this here.

47 The UKHSA corporate statement sets out PHE's health inequality duties and the work done during the early weeks in January 2020. I would also like to refer the Inquiry to the IANPHI report 'Lessons Learned from National Public Health Institutes' (Exhibit DS7 INQ000182706) which sets out a lessons learned exercise conducted with members relating to their role in the COVID-19 response in 2020. One of the case studies referred to sets out that there is now an opportunity to prevent future epidemics and crises by policies and services that enable healthier living environments and behaviours and strengthen individual and community resilience to infections and adversities. In terms of learning

lessons this may be a report that the Inquiry are interested in. My view, based on my 41 years in public service is that, notwithstanding the moral obligation, if we do not take care of the poorest and more vulnerable better, then no one can be safe, in essence, there is no safe population without a healthy population.

48 A final reflection is through my work with IANPHI, I see the importance of worldwide collaborative surveillance and finding a way of ensuring the world is capable of responding to catastrophic events together. For example, if there is a major infectious outbreak in India it will no doubt affect London in quick time. The WHO with IANPHI support are looking to create a standing capability in the world of scientists, public health professionals, and behavioural scientists in order to better prepare the world to deal with the next event. The Inquiry's findings and lessons will be important in a worldwide context to assist with this.

49 I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed: **Personal Data**

Dated: 24 May 2023